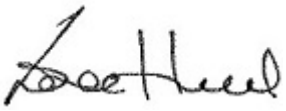
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **West Midlands Fire Service**
1	**CORONER** I am Louise Hunt, Senior Coroner for Birmingham and Solihull Districts
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 5 February 2024 I commenced an investigation into the death of Wayne Stephen BROWN. The investigation concluded at the end of the Inquest . The conclusion of the inquest was; Suicide
4	**CIRCUMSTANCES OF THE DEATH** Mr Brown was found hanging [redacted] at his home address on 24/01/24 after concerns were raised for his welfare. He was confirmed deceased by police at 10.50am. He had raised a complaint of harassment and had recently been suffering extreme stress arising from the ongoing harassment case and a recent work investigation regarding his qualifications which had become public. In the days leading up to his death nothing had indicated to others that he would take his own life but his intention to do so was clear from the note he left. Following a post mortem, the medical cause of death was determined to be: **1a Hanging** **1b** **1c** **1d** **II**

5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – 1. WMFS did not undertake any investigation after Mr Brown's death and have no policy requiring them to do so. Any opportunity to learn from a death such as a suicide related to work events including what welfare support was provided has not been addressed. This creates a risk of future deaths and action should be taken. 2. Neither WMFS health and wellbeing policy nor the mental health policy make any provision for supporting senior staff members who are facing significant stressors and/or potential disciplinary investigations beyond the person approaching Occupational health themselves. The policy offers further support to lower ranks. In addition, there was no formal mechanism for recording concerns about welfare that arise during either an informal or a fact finding investigation. This creates a risk of future deaths and action should be taken.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 15 July 2025. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: • The family of Mr Brown • West Midlands Police • Mr Walker I have also sent it to the His majesty's Inspectorate of Constabulary and Fire and rescue services who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

9	**20 May 2025** Signature:  **Louise Hunt** **Senior Coroner for Birmingham and Solihull**